DANIEL FIGHTS HIS PHANTOMS

How a Psychiatric Consultation Service Came to a Middle-Sized Community

EDITOR'S NOTE

This pamphlet, which deals with ways in which a psychiatric service became a part of a preventive and treatment program in a small community, takes its place beside a long list of Hogg Foundation pamphlets concerning children who have special needs. Predecessors to *Daniel Fights His Phantoms* include *A Family Grows,* dealing with family therapy; *Office in the Alley,* concerning work with gang youngsters; *No Place for Tommy, Children of the Evening,* and *The Worth of a Boy* about emotionally disturbed children; *Clearing in the Wilderness,* an overview of the mentally retarded youngsters; *Delinquency and Mental Health* and *Chance for a Life,* about delinquency.

We are pleased to add this report by Mr. Toland to the other pamphlets concerned with the needs of our youth.

Bert Kruger Smith

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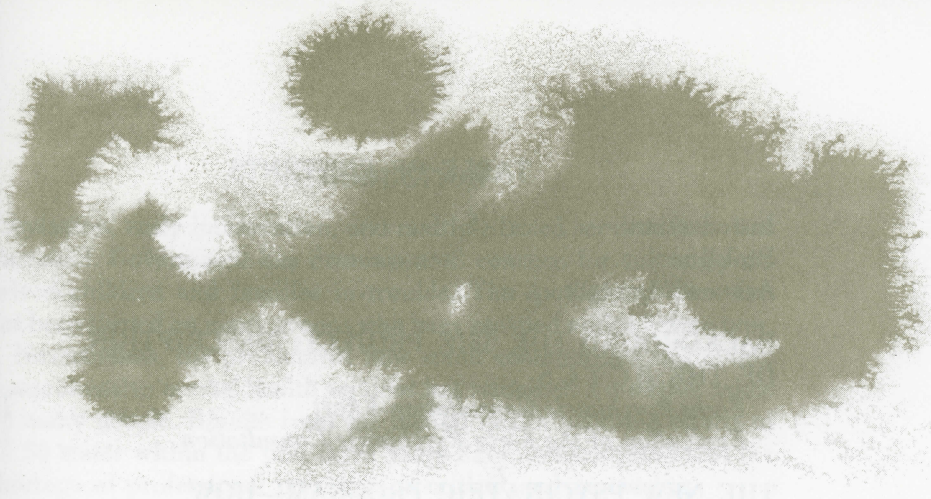
Came to a Middle-Sized Community

by Robert A. Toland

PRICE / 25¢



ABOUT THE AUTHOR

ROBERT A. TOLAND is now Chief Psychiatric Social Worker at the Austin Child Guidance Center. He was formerly Director of The Brazos County Youth Counseling Service for seven years, leaving that position to come to the Guidance Center in September, 1965. He holds a master's degree in Social Work from The University of Denver, is a member of Phi Beta Kappa and Alpha Kappa Delta, National Sociology Honor Society. Mr. Toland is married and has two children. He has written more than 500 newspaper articles on various aspects of child and family problems.

TABLE OF CONTENTS

INTRODUCTION

Prevention, early intervention, and multiple-based services are often discussed. Government has demonstrated concern for culturally deprived children and families in trouble. The spotlight of attention has been turned on many groups who have escaped notice before now.

Nevertheless, the problem of how small communities can obtain comprehensive mental health services has remained a question asked by many people. Results from the mental health planning efforts of all 50 states within the past three years have demonstrated that the shortage of professional personnel is critical and increasing.

The story of one community's solution to this problem, then, becomes significant to citizens of other communities hoping to set up such facilities. A long background of work between state and community agencies went into the project described in this pamphlet by Robert A. Toland, former Director of the Brazos County Youth Counseling Service. The Division of Mental Health of the Texas Department of Health worked initially with the City of Bryan in establishing a pilot project aimed at delinquency prevention. The Hogg Foundation aided with the operation for a period of several years.

The Youth Counseling Service demonstrates several rules of good community organization, as well as good mental health consultation. One basic principle in consultation is that such a facility can be of great benefit if it incorporates the skilled use of several behavioral specialties—psychiatry, psychology, psychiatric social work, and volunteers. Another principle is that the effectiveness of a community resource like this is facilitated by having it present in the community it serves and utilizing a network of referral services.

The pamphlet written by Mr. Toland, then, shows some of the ways in which the goals of helping to diagnose children's problems early, of providing direct services to families, and of giving consultation to physicians were met in the Bryan-College Station area.

This publication should be of special interest to planning committees in communities which have made some assessment of their mental health needs and are at the point of deciding what kinds of services are needed to fill those needs. Established agencies which are contemplating the addition of psychiatric consultation services may find this booklet helpful. It should also have value for all community leaders who are interested in improved mental health services.

Robert L. Sutherland, Director
The Hogg Foundation for Mental Health

PROLOGUE

This pamphlet contains a description of processes in the pioneering of a community mental health program; or, more specifically, the description of how a vital and effective psychiatric consultation program was initiated in a child and family counseling agency in a moderate-sized community which had no other voluntary psychiatric services, or no psychiatrist in private practice.

If the reader will approach these pages with a sympathetic heart, perhaps some hint of the real human drama can be captured—the drama that took place in the thousands of hours of counseling with the actual parents, children, and adolescents.

Here, you cannot see the mother's tears of hurt and desperation, or the father's angrily clenched fist, or the child's listless stare of utter bewilderment. You cannot see the glimmering hope and the growing determination in the mother's face, or the father's hand opening to take hold of his problem, or the child's face brightening with the unfolding joy of achievement. These things are there, though—between every line, behind every paragraph.

This booklet is respectfully dedicated to The Hogg Foundation for Mental Health, which made this project possible, and to the troubled parents and children who sought help, and who often were benefited by the application of the skills of those professional people who took part in the project. *Robert A. Toland*

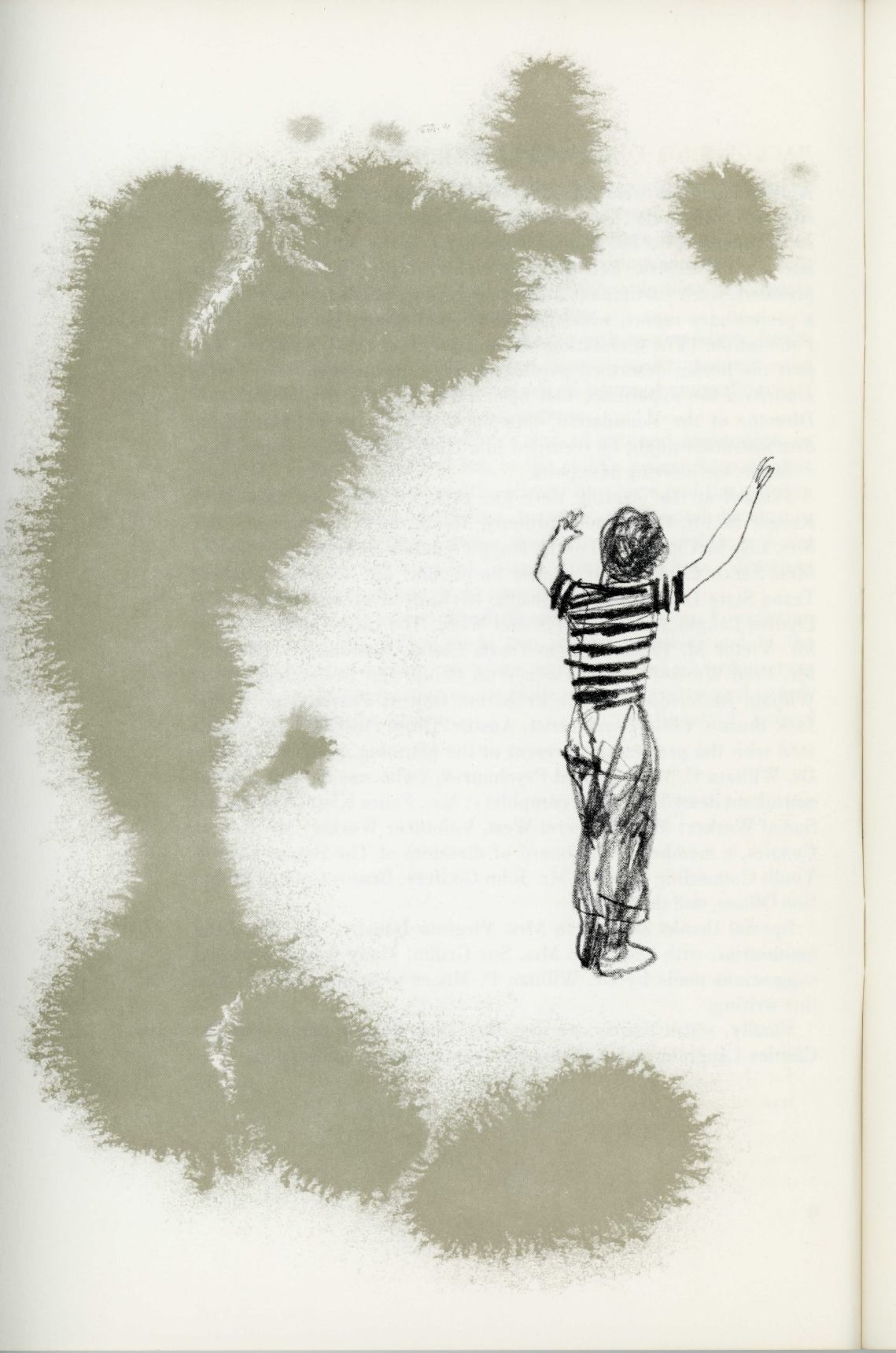
ACKNOWLEDGMENTS

A unique process went into this writing. A group of people, knowledgeable and skilled in the behavorial sciences was called togtther for a luncheon by Dr. Robert Sutherland of the Hogg Foundation, late in 1964. Mrs. Bert Kruger Smith of the Hogg Foundation presided. Each participant made suggestions, based on a reading of a preliminary report, which the writer had prepared for The Hogg Foundation. (The foundation had made a grant of $3,000.00 to support the herein described psychiatric program for one year, and a report on the experience had been agreed upon.) Dr. Sutherland, Director of the Foundation, thought that a report of this unique demonstration might be recorded in a Hogg Foundation publication —hence, the meeting of experts.

Present at the meeting were Dr. Robert Sutherland, Mrs. Bert Kruger Smith, Dr. Bernice Milburn Moore, Mrs. Etelka Lynn and Mrs. Lisa McClurken, all of the Hogg Foundation for Mental Health; Mrs. Sarah Conklin, Mr. James Smith and Mr. Charles Mitchell, Texas State Department of Health, Division of Mental Health; Dr. Charles Laughton, School of Social Work, The University of Texas; Mr. Victor M. Ehlers, Austin-Travis County Community Council; Mr. Fred Ward, National Council on Crime and Delinquency; Mr. William Anderson, Juvenile Probation Officer, Travis County; Dr. Jack Boston, Child Psychiatrist, Austin. Those most directly associated with the project also present at the planning meeting included Dr. William P. Moore, Child Psychiatrist, (who was the psychiatrist consultant described in this pamphlet); Mrs. Felice Klein, Psychiatric Social Worker; Mrs. Margaret West, Volunteer Worker; Mr. Robert Canales, a member of the board of directors of The Brazos County Youth Counseling Service; Mr. John Godfrey, Brazos County Probation Officer, and the writer.

Special thanks are due to Mrs. Virginia Dansby, who typed the manuscript, with help from Mrs. Sue Griffin. Many valuable critical suggestions made by Dr. William P. Moore were incorporated into this writing.

Finally, warm thanks are due Mrs. Bert Kruger Smith and Dr. Charles Laughton, who guided the manuscript to completion.



BACKGROUND FOR THE PROJECT: DESCRIPTION OF THE B.C.Y.C.S.

The Brazos County Youth Counseling Service was developed some ten years ago as a result of community concern about juvenile delinquency, and a desire to create a highly professional agency where curative as well as preventive counseling could be done with children and families. By 1954, enough community work had taken place so that a committee, The Youth Development Committee, had been formed. Through consultation with The Division of Mental Health, Texas State Department of Health, a psychiatric social worker was placed "on loan" from the Division, for a period of three years beginning early in 1955.

In spite of many problems, a great deal of community interest had developed by the end of the three-year "trial" period, and both aspects of the service continued—a full time probation officer was hired, as well as a separate, experienced psychiatric social worker to head The Youth Counseling Service.

A full story of the entire three-year experience is provided in a pamphlet *Talk is Cheaper* by Edith M. Stern. This pamphlet can be obtained from the Department of Mental Health and Mental Retardation, Community Services Division.[1] As the title indicates, the real selling point of the two services was based on the idea that the cost of "cheaper talk" which could help youth and families before serious trouble developed, would be much more modest than the terrible costs inevitably exacted in the apprehension and corrective attempts of youthful lawbreakers.

The Brazos County Youth Counseling Service was thus established in 1958 as a non-profit, charitable, community service agency, along the lines of a voluntary child and family social agency, with some of the functions of a child guidance clinic. According to Article II of the by-laws of the organization, the purpose of the agency was defined as follows:

> ". . . operating a counseling service, utilizing the coordinated services of the psychiatrist, psychologist, and psychiatric social worker, for the study and treatment of individuals—with emotional, personality, and behavior disorders and maladjustments; for the purpose of conducting research, for the purpose of promoting mental hygiène in the community . . ."

[1] For information, contact: Mr. Charles Mitchell, Coordinator of Community Services, Department of Mental Health and Mental Retardation, Box S, Capitol Station, Austin, Texas 78701.

In its operation, the agency has stressed the importance of early detection of emotional problems which, without treatment, may be expected to develop into more serious disorders later on. Being a part of the community served, the staff was acquainted with local problems, and had developed a network of referral sources. The agency was publicized and became rather widely known.

Thus the service fits several of the general criteria set forth by The Statewide Citizens Committee, which summarized its findings in the publication, "The Texas Plan for Mental Health."[2] In this pamphlet, recommendations were made for early detection and treatment of mental and emotional problems, in the patients' own community.[3]

EARLY PSYCHIATRIC CONSULTATION EFFORT

A general psychiatrist, Dr. Morriss Mills, had acted as consultant to the agency for several years.[4] He traveled up from Houston (approximately 100 miles from Bryan), and would see one or two patients during each visit, and he would also consult with the social worker about any cases upon which a psychiatric opinion was desired. This consultation took place on an average of about six to eight times a year, which was all the time Dr. Mills could devote to the agency. In 1962, the pressure of his growing private practice made it necessary for Dr. Mills to discontinue his visits to Bryan, and a search was underway for a new psychiatric consultant when the present project became possible.

EVALUATION OF THE EARLY PSYCHIATRIC CONSULTATION

It had been felt that the occasional visit of a psychiatrist had served at least to acquaint the community with the advantages of psychiatry in such a program. There was a detectable feeling among those who knew about the service, including clients and the board of directors, that a psychiatrist added an important dimension to the agency work. Cases of unusual complexity were seen or reviewed by the psychiatrist, who could advise new approaches in counseling.

[2] "The Texas Plan for Mental Health Service, Highlights and Recommendations," State of Texas, December 1, 1964—(Obtainable from Department of Mental Health and Mental Retardation, Capitol Station, Box S, Austin, Texas 78701.)

[3] Ibid. See especially, pp. 19–21 and pp. 25–26.

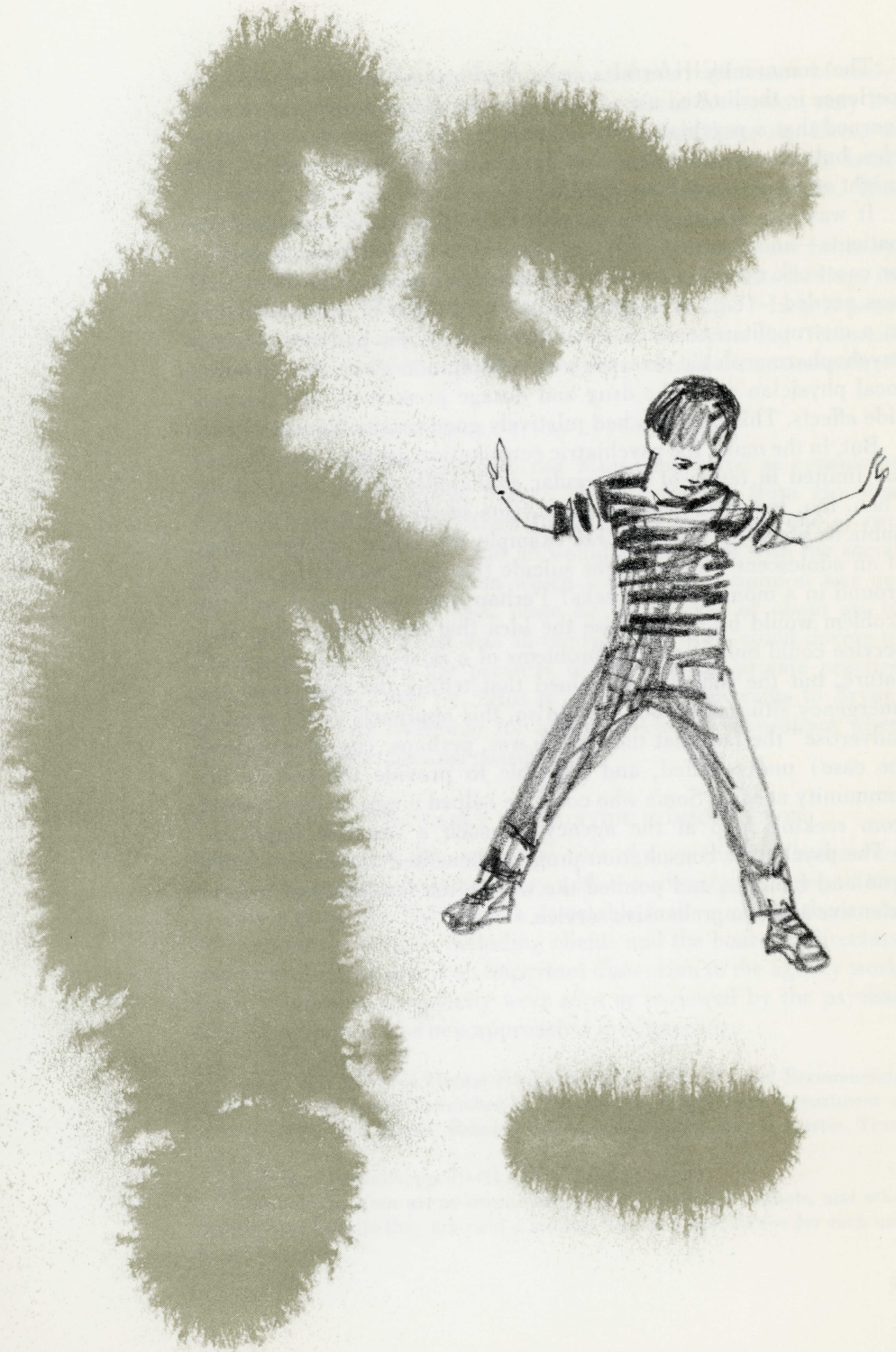
[4] Psychiatrists often act as consultants to social agencies, schools, and other institutions. Usually they are paid a retainer fee, or a specific fee for each unit of service.

The community referral sources had gained some valuable experience in the limited use of a psychiatrist. For example, the schools learned that a psychiatrically oriented service cannot perform miracles, but can often direct the application of helping approaches that might otherwise have been overlooked.

It was also felt that the psychiatrist's help was a safeguard for patients—and those who did not respond to the ordinary counseling or casework methods could be reviewed in order to see if referral was needed—(e.g., to a psychiatrist, neurologist or other specialist in a metropolitan center such as Houston. A few patients received psychopharmacologic therapy, with consultation given the attending local physician as to the drug and dosage prescribed, and possible side effects. This program had relatively good results in most cases.)

But, in the main, the psychiatric consultation program was deemed too limited in terms of the regular availability of the psychiatrist. Then, too, less than once-a-month visits seemed to preclude active publicity about the program. For example, how do you tell the mother of an adolescent who threatens suicide that the psychiatrist may be around in a month or six weeks? Perhaps one way to deal with the problem would be to publicize the idea that the Youth Counseling Service could only deal with problems of a mild or "non-emergent" nature, but the difficulty remained that telling the mild from the emergency situation is not easy. Also, this approach would seem to "advertise" the fact that the service was, perhaps, (as often seemed the case) under-staffed, and not able to provide the service the community needed. Some who could be helped might be discouraged from seeking help at the agency by such a negative approach.

The psychiatric consultation program benefited a number of children and families, and pointed the way to the feasibility of a more extensive and comprehensive service.



THE NEW PSYCHIATRIC PROGRAM—HOW "DANIEL" OPENED THE DOOR FOR THE PROGRAM

Five-year-old Daniel was afraid. Whenever he went to a strange place, he would open one door after another, and peer fearfully into each room. If people were inside, he would look carefully all around without focusing directly upon anyone, and then he would slam the door shut quickly, as though this would prevent something dangerous —perhaps a phantom—from escaping. An interview with Daniel at the Youth Counseling Service consisted mostly of loud door-slammings. If anyone touched Daniel, he would scream and pull away. Soon the staff knew when the small boy was present—because the doors would start banging. "It's Daniel's day," someone would say.

Daniel is not his real name, of course; but Daniel seemed like an appropriate name because the Biblical Daniel courageously survived in a den of lions. Our (frightened) Daniel walked about among people who appeared every bit as dangerous when seen through his distorted emotions, as real lions or perhaps phantoms would to the average person. For Daniel's emotional disturbance was so severe that he figuratively lived in a world of phantoms all the time. All his energy was consumed in fighting his entirely imaginary phantoms.

It is tragic for a child to live as though in a world of phantoms when he really is surrounded by people who love him and want to help! But this story has a happy development. For it was this same boy who opened doors with such fearful intensity who also opened the door which led to a brighter future, both for himself and several hundred other troubled children and adults in Brazos County.

A trip to the Houston State Psychiatric Institute[5] to secure psychiatric consultation for Daniel and his parents, was the real door-opener.

The child psychiatrist who was assigned to see Daniel at the Institute was interested in the detailed social history which had already been compiled by the Youth Counseling Service. This material, together with additional interviews with Daniel and his par-

[5] H.S.P.I. is a training facility for psychiatrists and other professionals in the field of mental health. Located in Houston, Texas, H.S.P.I. constitutes a part of the Baylor Medical School. The Child Study Clinic under the direction of Dr. Irvin Kraft, provides a broad range of services, but cases are chosen primarily for their "teaching" potential, rather than for service purposes only. Cases are referred from all parts of Texas. The bulk of referrals are from Houston and Harris County.

ents, helped the Institute staff to arrive at a diagnosis. Daniel's emotional disorder was felt to be so serious that a children's residential psychiatric hospital treatment situation was recommended for him. However, the hospital was too far away and too expensive for Daniel's parents to afford. It was decided to begin out-patient psychiatric treatment for Daniel, under a psychiatrist at the Institute. An Institute psychiatric social worker was assigned to counsel with Daniel's parents, a very important part of Daniel's treatment.

While discussing Daniel with Dr. Irvin Kraft, Director of the Child Clinic of the Institute, Mr. Toland mentioned that the Youth Counseling Service was looking for a psychiatric consultant to replace Dr. Morriss Mills. Mr. Toland explained how Dr. Mills had come to the Youth Counseling Service on a once-a-month basis (or less often) since 1956, and how Dr. Mills' work in the agency had already made an impact on the community, so that the directors were enthusiastic about the value of this phase of the counseling program.

Dr. Kraft showed an immediate and keen interest in the structure, history, and function of The Youth Counseling Service. Having engaged in community psychiatry earlier in his own professional experience, Dr. Kraft knew both the value to the community and many of the problems associated with providing this kind of service. Dr. Kraft stated that the Institute had been considering the possibility of placing a fellow in child psychiatry in a community setting where he could gain experience in an area in which some preparation had been made for the use of a child psychiatrist. From the standpoint of the Institute, the Bryan agency would be considered a "satellite" of The Houston State Psychiatric Institute. The many kinds of problems referred to the Youth Counseling Service would provide an excellent experience for the psychiatric trainee, and everyone who came to the Counseling Service would receive the benefit of the latest psychiatric knowledge and skills.

Several communities had made requests for the services of a fellow in child psychiatry from the Institute. But most of the other communities lacked a professional setting such as that of the Youth Counseling Service, which was already established as a child and family agency. Here, the professional skills of psychiatry, social work and psychology had already been at work for several years. Here also was an agency which already employed two psychiatric social workers who could carry out in daily practice many of the recommendations of the consultant. Whether treating a psychotic child, or a problem between husband and wife involving everyday child disci-

pline problems, the psychiatric consultant would add a new dimension to the counseling service.

(The relative soundness of the agency, as viewed by the medical community was shown in the fact that approval was given, both by the Harris County Medical Society and the Brazos-Robertson County Medical Society, for the initiation of the project. This approval was obtained in writing from both medical groups by Dr. Moore, before the project was actually begun. The importance of obtaining proper medical sanction for an undertaking such as this cannot be minimized.)

The agreement reached with the Institute also illustrates a point which deserves special comment, from the standpoint of organizing needed community services. The point is this: sometimes two not necessarily compatible needs will be found to dovetail very nicely—a happy outcome. In this case, the Institute needed a training experience for a fellow in psychiatry (a trainee) and a community needed the services of a psychiatrist. Both needs were met by the assignment of the psychiatric trainee to the Counseling Service in Bryan!

In a remarkably short time the basic agreement was reached whereby a fellow in child psychiatry from the Institute could come to Bryan, to direct the medical services of The Youth Counseling Service, on a weekly basis. But one important problem remained—that of paying the psychiatrist's expenses and providing a modest stipend. This problem required several months to solve. But the money problem did not delay the beginning of the psychiatrist's work at the Counseling Service.

A modest stipend and expense allowance of approximately $4,000 annually[6] was agreed upon.

HOW THE NEW PSYCHIATRIC CONSULTATION PROGRAM WAS FINANCED

The problem of the financial support of the new program was taken to the board of directors of The Youth Counseling Service. A special committee was set up to study means of finance for this new

[6] The actual calculation was as follows: $60 per day for the psychiatrist's stipend, and $24 per day for necessary expenses, or a total of $84 per day. This is in no way a suggestion as to what a psychiatric trainee's expenses would be in another setting. The type of setting, the amount of responsibility the psychiatrist would carry, his own relative degree of competence, the distance traveled, the frequency of visits, and many other factors would determine the fee of the consultant.

venture. Thus, a number of community leaders gave unselfishly of their time in order that troubled children and their parents could receive a better counseling service.

First, it was determined that the proposed psychiatric program held much promise for increasing the effectiveness of the service.

Naturally, since a psychiatrist had been present less than one-fourth the time proposed in the new program, the question was raised about buying only a portion of the service. It was made clear by Dr. Kraft that this could not be permitted—less than weekly visits to the agency would not provide sufficient training experience for the fellow in psychiatry. Incidentally, more than one day a week could not be promised, either, because of the psychiatrist's other commitments. Thus, the choice was clearly to take the whole "package," or none.

It was anticipated that the psychiatric consultation would be undertaken for a period of one year. By then it would be clear whether or not the project had merit. A decision would then be made to continue the program or not, on the dual basis of the effectiveness of the consultation and treatment service in the agency, and the effectiveness of the experience for the psychiatric trainee.

Finally, Dr. Kraft assured the board that, should the first experience prove successful, a second psychiatric trainee would take up where the first had left off. Thus, the program could go on without interruption, with a new fellow in child psychiatry, when the training experience of the first was completed.

Some critics of the program pointed out that there would be some disruption occasioned by having a new fellow in child psychiatry come on the scene at intervals of from one to two years. Admittedly, it works an emotional hardship on a patient to "shift" him to a new therapist after he has gone through the painful process of learning to trust and confide in someone. However, it was noted that the psychiatrist's main preoccupation would be with the many new cases which are inevitably handled in a community agency of this type. He could help to determine where the limited staff treatment time could be employed with the greatest effectiveness. He would accept for continued treatment those cases which seemed likely to respond to therapy in the allotted time he would be coming to the agency. The relatively "long term" cases would be assigned to a more "permanent" worker. Also, the consultant would spend a major portion of his time consulting with staff members about their cases.

It might also be pointed out that the vast majority of cases seen in the agency are of the short-term variety. This means the service is

completed within a few weeks to a period of three to six months. To put it another way, most service plans can be expected to encompass a period considerably shorter than the tenure of the psychiatric trainee. In the meantime, the relatively permanent status of the full-time staff provides a stabilizing influence.

In order to get the program underway with minimum delay, the board of directors agreed to employ the psychiatrist as soon as possible, and use the funds already on hand in the budget, for as long as this would last. (About $1,000 was available.) In the meantime, several channels were to be pursued in order to locate enough money to finish out the year (about $3,000 was needed). It was decided to approach the agencies that already provided funds to The Youth Counseling Service. If this should fail, the Division of Mental Health, Texas State Department of Health, as well as a private foundation, The Hogg Foundation for Mental Health, were to be contacted.

A great many negotiations took place in the next few months. The finance committee of the board, as well as most of the directors, was active in these negotiations. Additional local funds (primarily from the City of Bryan) were unobtainable during 1963, although an increase was anticipated at a later date from this source. The committee deemed it unwise to ask the City of College Station for additional funds, as a sizeable increase had been granted the previous year. The two city United Funds could not be approached in time to keep the program going; moreover, it was unlikely they could have supplied the amount needed, in any case. The Division of Mental Health was keenly interested in the present plan, since the Division had helped to establish the basic community service in the first place. Helpful suggestions were offered by the Division, but no funds were available from this source.

Finally, an agreement was reached with The Hogg Foundation for Mental Health, whereby the needed funds could be obtained for one year of operation of the program. The Foundation Director, Dr. Robert Sutherland, suggested that this might be conducted as a unique pilot project in giving direct service and consultation in mental health.

THE SERVICE IS STARTED—HOW DR. MOORE HELPED DANIEL:

When the fellow in child psychiatry, Dr. William P. Moore, started coming to The Youth Counseling Service on a regular basis,[7] he saw

[7] February 1, 1963. Dr. Moore continued his weekly visits throughout 1963, and until August of 1964 when his training was completed and he was replaced

Daniel during each visit, and Daniel's parents no longer had to make the weekly trip from Bryan to The Houston State Psychiatric Institute.

Daniel's parents received weekly counseling sessions from a psychiatric social worker on the staff. In this way, they were able to discuss their own deep disappointments in, and concerns about, Daniel. The social worker, in close contact also with the psychiatrist, and knowing what was likely to be most therapeutic for Daniel, would suggest ways in which Daniel's mother and father could be more helpful to their son. An important part of Daniel's treatment, indeed, was the management of the home situation, by parents who now had a better understanding of what could benefit their son.

Later, a more intensive treatment plan was established for Daniel, whereby he was seen three times a week at The Youth Counseling Service by a volunteer counselor. This new plan resulted from a special review of the case by Dr. Peter Neubauer, a visiting lecturer to The Houston State Psychiatric Institute. Dr. Neubauer is a child psychiatrist who has done special work with severely disturbed children in a day hospital setting in New York City.[8] Dr. Moore reviewed the case periodically and advised the volunteer on the meaning of Daniel's symptoms, and his treatment.

It is significant that, with the help of the Youth Counseling Service, Daniel's symptoms diminished greatly. His frightening "phantoms" were replaced with real, flesh and blood people whom he could begin to know and trust instead of avoid! Daniel's fight against his phantoms was beginning to succeed. He no longer opened and slammed doors so fearfully. He had truly opened the door to a more promising future!

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by another fellow in child psychiatry, Dr. Mae McMillan, Dr. Moore's professional training included a B.A. degree from The University of Texas, (1950), a B.S. from East Texas State Teacher's College (1952), his M.D. from The University of Texas Medical Branch, Galveston (1956), extensive service in the U.S. Navy, and his residency in General Psychiatry at the Houston State Psychiatric Institute. At the time he began his work at The Youth Counseling Service, Dr. Moore had completed his training in adult psychiatry, and was a fellow in child psychiatry. Actually, Dr. Moore was already in his fourth year of psychiatric training.

[8] The therapy undertaken in this case was after the order of "Corrective Object Relationship" (COR). See Alpert, A., "A Special Therapeutic Technique for Certain Developmental Disorders in Prelatency Children." *American Journal Orthopsychiatry*, 27–256–270, 1957.

The image and stereotype projected by the appearance of a psychiatrist may be demonstrated by the following incident. Dr. Moore was being introduced to some community leaders by the director, Mr. Toland. One man turned with a smile to an associate: "My friend, here, has needed to see a head shrinker for some time. Dr. Moore, did you bring your couch along with you, so you could go to work on him?" This half-humorous, half-serious remark is typical of one reaction to the psychiatrist's appearance in the community. But an even more frequent reaction was one of acceptance of Dr. Moore as a man of friendliness, intelligence, and unusual personal charm. Some people, by their responses, revealed that they had imagined a psychiatrist would be a bespectacled, bearded individual, who could probably "see right through them." Dr. Moore dispelled this image, and replaced it with a much more accurate idea of what a psychiatrist is really like—a person, certainly one of special training and qualifications, but one who would be easy to get to know.

One of the goals established with Dr. Kraft at Houston State Psychiatric Institute, for the training and use of the consultant, was that of the introduction of the psychiatrist to the community.

For this purpose, it was arranged that Dr. Moore would meet with various groups. On one occasion, he had luncheon with a large group from the board of directors. On another occasion, he visited the superintendent of the public schools. A luncheon was arranged with a group of school counselors. He was given a tour of the County Courthouse, and chatted with the county attorney, the district judge, and the probation officer. Altogether, Dr. Moore met many of those deemed most important to be informed about the new psychiatric program in the community, and those who were in a position to make referrals to the agency.

Early in his consultantship, contact was made with several physicians, members of the Brazos-Robertson County Medical Society, which, as was reported earlier, had already approved the basic ideas in a letter to Dr. Moore.

This aspect of the psychiatrist's relationship to the local medical society was felt to be of extreme importance. Back of this lay the principle that the physicians of any community are the first line of defense against minor and major mental illness. Any service that proposes to deal with people who have mental problems needs the approval, if not the active support, of the physicians of the community.

In the formative and early years of the B.C.Y.C.S., the "medical community" had been taken into account in various ways. In each case, permission to talk with the family physician had been routinely sought. Physicians had been asked for written reports and had been sent reports on the nature of the work with the child and family where feasible. The staff soon came to know that some physicians were warmly interested in the agency, and some were lukewarm or indifferent about it, while, in a very few cases, there was an active antagonism.

In the years before the Y.C.S., people with child and family problems had been treated solely by local doctors, or had been referred to psychiatrists or medical services in other cities. (Houston, Waco, Austin, Dallas, Fort Worth and San Antonio were the principal cities used for this purpose.)

A few specially trained professors on the staff at A&M University had done some counseling with local people, but only one clinically trained psychologist was on the staff, and his services were limited to students.

It might be added that no psychiatrist was practicing locally. One objective of the psychiatric consultation project was to demonstrate the need for such services. It was anticipated that the psychiatric consultation program, already demonstrated as a part of the Youth Counseling Service, could then be carried on by the local psychiatrist, an added incentive for him to come to Bryan-College Station to set up his practice.

When Dr. Moore began his work at the B.C.Y.C.S., every appropriate effort was made to get him in contact with the local physicians. Usually this was done in specific case consultations. Dr. Moore was invited to luncheons with some of the local physicians and was urged to think seriously of coming to Bryan to establish his practice when his training was completed. (Dr. Moore had other plans, however.)[9]

One probable indication of some mixed feeling in the local Medical Society about the Y.C.S. program was the hesitancy in having Dr. Moore appear officially before them. This was achieved on March 17, 1964 more than 13 months after he actually began his work in Bryan.

LOCAL T.V. PROGRAM USED TO INTRODUCE PSYCHIATRIST CONSULTANT

Dr. Moore appeared on a local television program, used to introduce interesting people and services to the viewing audience. On this pro-

[9] Dr. Moore is presently engaged in private practice in Houston, Texas.

gram an informal "panel" discussion was conducted for several weeks, and people sent in questions about general topics which could be discussed on the air. Specific personal questions were not answered, however, but those who wished to were encouraged to call the agency and arrange for an appointment.

One of the amazing developments coming out of the T.V. program was the discovery that the master of ceremonies and Dr. Moore had lived in the same town, and had played together as kids! This amusing incident illustrated another point, important in developing acceptance of the program. Everyone knew the master of ceremonies, and since she knew Dr. Moore so well, he became increasingly acceptable to those who admired the M. C.! Several referrals were received as a result of Dr. Moore's appearance on this program.

OTHER PUBLICITY EFFORTS: DR. MOORE'S SPEECHES

Early in his consultation period, Dr. Moore appeared before The Brazos County Council of Social Agencies which, as the name implies, is made up of representatives from all the principal social agencies, churches, and civic organizations in the county. Dr. Moore was guest speaker to this group. He was introduced by the writer, who described how Dr. Moore had come to be psychiatric consultant for the Youth Counseling Service. Dr. Moore spoke on the role of psychiatry in the community agency. Afterwards, there was some discussion of types of referrals to the agency.

Dr. Moore was invited to speak to the Kiwanis Club of Bryan about the same time. (The program was arranged by a board member who was also a member of Kiwanis.) Afterwards a number of members raised questions on the role of the psychiatrist in a community agency. It was evident from the questions raised that some members were thinking about how a psychiatric consultation could be of benefit in their own family situations!

Originally, it had been planned that Dr. Moore would appear before practically all the civic clubs of Bryan and College Station, but this project evidently was overambitious. Many cases were being referred to the agency, and Dr. Moore's time was required for the direct service aspect of his consultation program. Also, since he was present only one day a week and the clubs met at other days through the week, special arrangements would have had to be made. One board member proposed that a private plane be engaged to fly Dr. Moore up from Houston for these meetings, but this unusual procedure was never put into effect.

NEWSPAPER PUBLICITY USED

The director arranged for an interview with the editor of the local daily newspaper, and Dr. Moore's picture, together with a description of his qualifications, appeared in a front page article in the paper, which also carried an accurate description of the agency's aims, as well as a brief explanation of how the psychiatric consultant would serve the community through the agency.

This feature did not, however, conclude the newspaper publicity on the psychiatric consultant. The director had, for several years, been producing a column for the local paper. This column, which appeared in the Sunday supplement, apparently had a wide readership. It dealt "indirectly" with the agency in many respects and was actually an educational feature on some phase of mental health (usually child and family problems and their solution or prevention.)

This column now was used for a month-long series of articles on the new psychiatric consultation program in the agency. Several referrals resulted from this publicity.

Dr. Moore also appeared at a monthly meeting of the board of directors of the Youth Counseling Service, a widely representative group of business, professional men and women, housewives, and civic leaders. All ethnic and geographic areas were represented. The directors acted as a "sounding board" for "sending out" and "receiving" public opinion, and members had many opportunities to tell others about the new service.

Near the end of his training assignment, in July, 1964, Dr. Moore made another appearance of great importance to the future of the psychiatric consultation program in the agency. This will be described later.

FORMER CLIENTS AGENTS OF PUBLICITY

In one study, made for the 1962 annual report, it was discovered that 5¾ percent of the children, and 3 percent of the parents of the total population of Brazos County, had already been seen for direct counseling at the agency. A year later, when the present project began, a somewhat larger percentage of the population had received direct service.[10] Thus, a significant number of the population had received direct services, and, of these, a fair proportion could have been spokesmen for the service.

There was a hard-to-measure, but detectable "word-of-mouth" in-

[10] Annual report of B.C.Y.C.S., 1963, p. 4.

terest in the service, which helped also to spread the news about the psychiatric consultation program.

SPEECHES AND PUBLIC APPEARANCES BY STAFF

During any period, the director and other staff members are asked to make talks to church, clubs, and civic organizations. Between 15 and 20 of these talks were made by the director and the staff members during the period of the psychiatric consultation program. Of course, these talks provided still another opportunity to tell about the program and answer questions about referral procedures.

(One amusing anecdote, which gives some idea about the growing popularity of the agency, was reported by a board member. It seems a Bryan clothing store, which catered to the needs of children, was named "The Youth Center." The store got so many calls from people who were seeking "The Youth Counseling Service" that the store, a business of many years standing, finally saw fit to change its name, in order to avoid further confusion with the social agency!)

THE TRUE PREVENTIVE FUNCTION OF THE SERVICE: EXAMPLES OF LESS SERIOUSLY DISTURBED CHILDREN

"Daniel's" case, which was described earlier, represents a much more serious disturbance than one ordinarily encounters in a child and family counseling agency. During the time Dr. Moore came to the Youth Counseling Service, only 10 percent of the children seen, represented problems complicated or serious enough to require referral to, or consultation from, medical or behavioral specialists other than the attending physician, the school teachers or counselors, or the regular staff of the agency (including the clinical psychologist.)

The vast majority of the cases were of a nature which could be expected to yield rather readily to individual, family, or group consultation, or counseling therapy, of a longer or shorter duration.

Examples of cases which received relatively brief therapy, but which showed marked improvement, are the following:

"Carl" was an unusually shy, effeminate 11-year-old, who played mostly with girls, and was shunned by boys. Psychological examination showed Carl to be of above average intelligence, but with many girlish preoccupations, and an avoidance of anything aggressive or masculine. The case history revealed a preoccupied father, absent from home much of the time, and a fussy, overprotective, but devoted

mother. Two older sisters did their share of babying their only younger brother.

Therapy consisted of direct therapy sessions with Carl, who saw the psychiatrist on a weekly basis, and joint as well as individual counseling sessions with the parents. These sessions were conducted by a psychiatric social worker. The father was encouraged to become more active with Carl, the mother and sisters less preoccupied with him. In a period of six months, there was a marked improvement in Carl's ability to relate to other boys. In addition, there was a noticeable improvement in his scholastic performance.

"Barbara" was an attractive 16-year-old who was referred by her parents after she defied them and insisted on keeping company with companions of whom they severely disapproved; not without reason, as these were youths with "probation office" records.

Barbara revealed a history of unhappiness that seemed to stem principally from a loveless home situation. Barbara was evaluated as essentially an emotionally healthy adolescent who was reacting to a mother who was overly concerned with her own ills, and a father who used his job as a way of escaping family responsibility. There was danger, however, that she would become pregnant, and steps were taken to provide safeguards through strengthening parental ability to cope with her needs.

"Joe," age 5, was refusing to eat, and his mother's urging only seemed to intensify his stubbornness. Three consultations with the social worker and psychiatrist were enough to identify the main features in the power struggle between mother and son, and get the boy on a road to a more normal eating pattern.

Approximately a hundred children[11] and one hundred seventy-five parents were seen during the period of the project (July 1, 1963–June 30, 1964). Of these, about 10 percent of the children were referred to some other facility for additional diagnostic work, in addition to that which the staff conducted.

Of the adults seen, the vast majority were given counseling in connection with the problem presented in the child. However, in a few cases, serious pathology was discovered in one or both parents, and referral was made to some other facility for treatment. (e.g., a psychiatrist in a metropolitan area, such as Houston.)

[11] A "child" is defined (for the purposes of this writing) as anyone below the age of eighteen. The breakdown was as follows: Children, ages 1–6, 12; children, ages 6–12, 40; children, ages 12–18, 37; Total 99.

HOW THE TOTAL FAMILY IS INVOLVED IN COUNSELING

The total family is involved in the counseling service, both by means of the philosophy of the agency and by arrangements which are made for counseling.

It is the policy to see parents first, before evaluating the children. This says to the parent: "We are interested in you. You are the really important one to your own child. Beside this, you are the one who knows his problems, and are the one best equipped to tell us what is the matter, as well as what you have done to try and cope with the problems. We'd like to consider with you the goals you have for your child or family situation, and what you think we can do to help. Finally, only if we work with you, can we achieve the most constructive course of action for your child and for your family situation."

In actual practice, about two-thirds of the time in counseling is spent with the adults of the family, instead of the children. Also, a study conducted in several recent years showed that from 26 to 38 percent of the cases involved marriage counseling as part of the principal service rendered. (In about one-half the cases involving marriage counseling, a child problem was also considered and treated. In the other half, the child was not counseled directly, but only the adults were seen.)

The vast majority of cases, of course, involve counseling with one parent, (often the mother) and the child. In almost all cases, fathers are seen, for at least one evaluative appointment, as well as an occasional concurrent appointment. In some cases, fathers are seen on a weekly basis.

Finally, it may be well to mention that in appromixately one-third of the applications for service, it is the father who makes the original contact. In these cases, the father is almost always an active part of the ongoing therapy.

PROCEDURE IN ACCEPTING CASES AND SEEING PATIENTS

In the typical case, the client-to-be calls the office and talks to the secretary-receptionist who takes the application information, fills out a "face sheet" of information, explains service procedure, and answers questions. The secretary also makes a tentative evaluation of the seriousness of the problem, and its emergent features. As soon as possible, the case is assigned to one of the workers, or the volunteer, or a student. This person then calls the applicant and sets up an appointment.

Here a word of explanation is necessary. In many a social agency of this sort there is a lengthy waiting list, which acts as a "cooling off" period between the time of application and the time the applicant is actually seen. In the Youth Counseling Service the waiting list has so far been avoided—a "long" waiting period would be two weeks, while the applicant is often seen on the same day of the "crisis," or one or two days later.

This procedure may account for part of the generally high effectiveness of the service. The practice has been carried out both by design and by practice, in order to see the patient as close as possible to the point of his crisis, and give help when the individual and family is most amenable to change.

A waiting list does exist—but this is for "extended treatment service," and comes after the parents are interviewed, the child seen and evaluated, and a psychiatric consultation arranged (from which a tentative diagnosis is made).

Some social histories are completed by one of the psychiatric social workers, or by the volunteer with the supervision of one of the social workers. The child is usually also seen by the social worker, and an assessment is made of the problem and his strengths and weaknesses. Sometimes the child is given a simple test by the social worker (e.g., Otis intelligence test: or one of several "projective" tests). In some cases, where deemed feasible, the parent is given a test also—usually The Minnesota Multiphasic Personality Inventory. All these test results are studied by the psychiatric consultant, who, together with the staff, determines the diagnosis and treatment plan.

A fee is discussed, and set if applicable, usually by the social worker or volunteer during the first appointment.

Plans are made for a psychiatric examination for the child and/or parent(s), also during the first or second appointment. (If necessary, a second or third appointment may be made with the parent(s).)

The psychiatric consultation is preceded by a briefing of the psychiatrist by the person who has started the workup on the case. The patient, usually the child, is then seen by the psychiatrist, who often then does a mental status examination on the child. Immediately after this, a brief conference is arranged with both parents (who are urged to accompany the child for the psychiatric examination). Depending on the case situation, the social worker is usually present with the psychiatrist for all of these conferences. A brief joint conference is usually then held, between parent(s), social worker (or volunteer), and psychiatrist. A diagnosis is made, and discussed with

the parents, and a treatment (or counseling) plan is set up. If the situation is emergent, or if staff time is available, assignment is made of the child and one or both parents for counseling, usually on a weekly visit basis. If the situation is not emergent and there is no time available for assignment on the social work treatment schedule, then the family may be told they will be called and told when assignment is possible. In the meantime, occasional interviews may be arranged, or the parent may call in for brief telephone counseling or an interview, from time to time.

Incidentally, the staff conducts a good deal of counseling over the telephone.

Thus, most cases receive "brief therapy" close to the time of application for service, while the "long-term" treatment list may be several months to a year or more in length.

Successive crisis situations are met, close to the time of the crisis. Probably this helps to account for the effectiveness of the whole counseling program.

GROUPS WHO NEED THE COUNSELING SERVICE

A question may be raised about those who used the Youth Counseling Service. In general, there were two groups: a rather highly verbal intellectually-oriented middle class, and a less verbal middle and lower class. Among these, several groups may be identified and are listed here, in terms of frequency and effectiveness of the use of the service:

1. Middle class business and professional families, including such professionals as teachers, university professors, nurses, and employers as well as operators of small to moderately large businesses.
2. University students and their youthful families and children (principally from nearby A&M University).
3. A group which maintains both a professional role (e.g., university teaching) and a rural interest (e.g., cattle or poultry farming).
4. The more "non-verbal" group included: culturally and economically deprived families, living on borderline incomes. This group included cases referred primarily because of the anti-social acts of one or more children (so-called juvenile delinquents) or the gross neglect of some child or children. (This latter group of cases is usually referred to a child welfare unit, if such is present in a community.)
5. Rural families, usually farm laborers or managers, mostly second and third generation Italian-American and Polish-American families from the nearby farming areas.

6. Ethnic groups; Negro families and a very few Latin-American families. (Skilled and unskilled laborers, for the most part.)

Among the latter groups, voluntary services were often sought, not so much to resolve child or family emotional problems, as to use the service as a "lever" to accomplish some end the family had chosen to accomplish. (Example: the placement of a child in a hospital or special school.) However, a number of the "non-verbal" families were referred by some other agency, such as the school or the probation officer. In this case, a somewhat more aggressive casework policy was sometimes followed—that is, the social worker would visit the home and try and engage the family in a cooperative plan. In a few cases, it was also decided to bring the psychiatric consultant to the family, rather than the other way around. This plan proved very successful.

Also a social work student[12] made up about half of his caseload from this group of patients. (Approximately eight or ten cases.) He used an aggressive casework technique, with a group of patients who were non-verbal, oriented to physical services (e.g., "clothing for the children"), or behavior problems. About half the cases treated in this manner required frequent home visits.

By far the largest proportion of the services were rendered to people in the more sophisticated groups. In part, this is because these groups referred themselves and were generally very cooperative and persistent about following through on service, including treatment plans involving a series of office visits.

In summarizing this point, it is felt that there is a failure, in an agency such as this one, to reach out into the community sufficiently to serve adequately the needs of all the more non-verbal, and most "disadvantaged" groups. Yet, it is also significant that every group was represented in the clientele of the agency, thus, efforts to serve were at least partially successful.

DEPRESSED MOTHERS

There was a noticeable and dramatic change in the type of cases referred to the Youth Counseling Service after the psychiatric consultation began. Local physicians, in addition to increasing the number of referrals of children's cases, began to refer more depressed mothers. At first, a number of these cases were accepted for evaluation and extended treatment service, but gradually a realization came that this service was "loading down" the rather limited staff

[12] One of the students from The University of Texas School of Social Work. The agency has served as a field work placement.

time, with chronic, often emergent cases, which required additional appointments over and above that allotted the usual child-family counseling cases.[13] Some of the mothers seen required careful adjustment of medication, and hospitalization as well. Clearly, this procedure was going beyond the usual demands placed on the service, and, as a result of several thoughtful consultations with the psychiatrist, it was decided to refer future depressive patients either back to their family physicians or on to a psychiatrist in larger metropolitan areas. (Houston, Waco, Austin, or other cities.)

In a few instances, it was possible to refer some depressed mothers (the wives of Air Force Officers) to their respective service hospitals for psychiatric treatment.

The whole situation gave added emphasis to the need for a full-time, local psychiatrist, to whom physicians could refer.

Incidentally, in cases where the child was seen as emotionally disturbed, his parent(s) would still be seen for treatment, whether or not there was a problem of depression in the parent(s).

FUNCTION OF VARIOUS STAFF MEMBERS

A Psychiatric Social Worker is director of the agency, although other disciplines may be in this position in other agencies. Where the agency has a full time psychiatrist on the staff, it is common for him to be the director. Sometimes, administrative duties are carried jointly with two or more professionals.

The psychiatric social worker is trained in clinical work and is skilled in understanding the dynamics of human behavior. He forms a member of the "team" in clinical work. The "team" is composed of a psychiatrist, psychologist, and psychiatric social worker, collaborating, and coordinating their efforts. In the teamwork approach, the psychiatrist takes primary and overall medical responsibility for the case, and makes the final determination as to whether a problem is basically organic, a major psychosis, a psychoneurosis, a character disorder, or a situational type of reaction. (Many problems represent a mixture of the foregoing.) The psychologist lends able assistance in this diagnostic process, and ordinarily administers one or more of a battery of tests which will determine the patient's intellectual function, and his psychological makeup, or attitudes about himself and others, as well as his characteristic ways of behaving. Psychological tests are useful tools in helping to spot organic disorders, major psy-

[13] The rationale for this service was that of "prevention" of problems in offspring by treating the mother, and pulling her, if possible, through a crisis state.

choses, and various types of emotional, interpersonal, and situational problems.

The psychiatric social worker is skilled in obtaining case histories and in assessing strengths and weaknesses in family situations. In traditional practice, the role of the social worker remains primarily with the parent (or parent substitute) as distinguished from the child, but recently there have been changes in this pattern. For example, in the Youth Counseling Service, psychiatric social workers have often worked directly with children, and have conducted individual and group child therapy, under the supervision of the psychiatric consultant. Also, the psychiatric social worker has ordinarily been responsible for contacts with schools and other agencies, and for arranging referrals. The only marked exception to this is that the psychiatrist has conferred with the medical doctor on many cases, especially about initial diagnoses and plans. But in cases carried in therapy by the psychiatric social worker, the worker has then taken subsequent responsibility for contacts with the doctor.

In the case of the Youth Counseling Service, the director encouraged the visiting psychiatric consultant to contact the attending physician whenever practicable, in order to "introduce" the doctor to the new psychiatric service and to encourage the referral of cases directly from physicians. (Incidentally, there was a marked upturn in physician referrals. As a matter of fact, during the period of this project, physicians became the chief sources of referral.)

One final point of clarification: In the usual "team" (psychiatrist, psychologist, psychiatric social worker) each and all members do treatment. However, in the case of the Youth Counseling Service, the psychiatrist's first and major responsibility was diagnosis, with treatment forming a somewhat secondary function, because of the scarcity of the psychiatrist's time.[14]

Also, at the Youth Counseling Service, the clinical psychologist (a consultant from nearby A&M University) did no treatment, but acted as a diagnostician and consultant. At the Youth Counseling Service, the major amount of the treatment was carried on by the psychiatric social worker. In other settings, psychologists may carry much of the treatment load.

[14] The amount of time spent by a psychiatrist consultant on various functions —treatment, diagnosis, consultation and supervision will depend on many factors. At the Y.C.S. this was the approximate proportion: Diagnosis 50 percent; Treatment 25 percent; Consultation 25 percent.

CONSULTATION WITH STAFF—A MAJOR FUNCTION OF THE PSYCHIATRIST

It may be helpful at this point to make a major distinction—namely, that of the medical responsibility carried by the psychiatric consultant member of the "team." In the typical clinical setting (and the author has worked in several) the psychiatrist acts as medical director of the overall service. Even though it is rarely possible for the psychiatrist to see, directly, every patient (or family) who receives some evaluative or treatment service, he nevertheless carries the medical *responsibility* for all the patients who receive service.

It is common for staff members to consult with the psychiatrist-consultant whenever a serious problem of psychopathology arises, or when a crisis arises involving the behavior of the patient (or family). In some cases, rather routine, psychiatric consultations are arranged. In by no means all of these situations is the patient (or the family) seen directly by the psychiatrist—rather, in most instances, the social worker, psychologist, social work student, or volunteer simply describe the situation to the psychiatrist, who in turn gives an opinion as to how the staff member should proceed. If the psychiatrist is not clear about the problem, or if he feels the presented problem warrants, then he may suggest that he see the patient, usually for a single interview. Afterward, the staff member can arrange a time for the patient to see the psychiatrist. Even though in most cases the psychiatrist may not see the patient directly, nevertheless, the psychiatrist's consultation will play a vital role in the ongoing conduct of the therapy. This is never so true as when the therapist becomes involved in a relationship (or countertransference) problem with the patient. This means the therapist may have lost some of his effectiveness in the treatment situation, because he has become "personally involved," as it were, with the patient. The psychiatrist can help resolve such a problem, due to his great skill in the inter- and intra-psychic processes.

The mother of an 11-year-old boy, originally seen because of school failure, revealed a deepseated dissatisfaction with her marriage, and threatened suicide. She sought to "line up" the social worker on her side, in her struggle with her husband. The social worker, who was a woman who had a certain unresolved problem with respect to her own marriage role, seemed about to become involved in this struggle. She was anxious, although she could not say why she was so troubled. A consultation with the psychiatrist helped her to see the problem

more clearly, resulting in a totally new direction in her counseling. Subsequently, the mother gave up her suicide threats.

Besides individual consultations, the psychiatric consultant was invaluable in consulting with the social workers and volunteers about several therapy groups which became one of the principal innovations of this period.

GROUP THERAPY INITIATED

Dr. W. P. Moore early encouraged the staff to undertake some therapy groups. He, himself, was the first to begin such a group. This was started in the spring of 1963 with adolescents. This group continued, with several changes of membership, for over a year thereafter, when it was taken over by one of the psychiatric social workers.

In the meantime, the staff members attended a Southwest Group Psychotherapy Institute, led by S. R. Slavson in Dallas in the spring of 1963. (Attending such an Institute is a valuable method in preparing for the beginning of group therapy in a counseling program, or in strengthening an existing program.)

A volunteer social worker,[15] took part in the new group which was started by a staff psychiatric social worker, under Dr. Moore's supervision. The social worker acted as group leader, while the volunteer became the recorder. (She wrote down, as nearly as possible, what each group member said, for later study and analysis.) This was a parent group, which started out as a "husbands and wives" group. (The children were seen separately for therapy.) However, the husbands quickly dropped out of the group, and the wives continued.

The writer became the leader of a pre-adolescent activity and therapy group. The activity of "model-making" was chosen by these youngsters, several of whom were hyper-active, and several of whom were withdrawn. The activity consisted of gluing together, and then painting, plastic models furnished by the children's parents. The model-making furnished a focus for the group of six or seven boys or girls, but the real therapy was in the interaction of the group, with one another and with the therapist. The more aggressive children tended to become more self-controlled, and the shy children became more assertive in the group. This behavior carried over at home and school.

[15] Volunteers are usually difficult to obtain for an agency such as the B.C.Y.C.S., because they must function essentially like members of the staff, and have access to the confidential files. In this case, the volunteer was a sociology major, the wife of an Air Force colonel, the mother of three. She had done "Gray Lady" work in a hospital setting, and expressed an interest in going on with graduate training in social work, when conditions would permit this.

Group therapy enabled a somewhat larger number of clients to be seen, an important consideration in a counseling service which is constantly handicapped by a shortage of time. (Incidentally, all of the patients seen in group therapy were seen first for individual evaluation, and in some cases, for individual therapy prior to entry into the group.)

Another consideration in group therapy was that of the appropriateness of the patient for such therapy. For example, no severely depressed adults were placed in a group. (This would tend to depress the entire group.) While groups existed for several age levels, no attempt was made to set up different kinds of groups according to similarity of problem. (For example there might be a therapy group for parents of retarded children, one for parents having marital difficulties, one for parents of adolescent behavior problems.)

The therapy groups became a new tool, to forward the aims of treatment and prevention, and they became a source of stimulation for the staff members as well.

USE OF VOLUNTEER

The volunteer, mentioned earlier, functioned in several ways, which may be listed:

1. She did initial case evaluations, which included taking a careful case history, and an assessment of the presented problem, in terms of strengths and weaknesses revealed in the client and his family situation.
2. She participated in staff conferences.
3. She carried a few cases under careful supervision.
4. She took part, as a recorder, in a therapy group.
5. When the agency began the necessary work to initiate a mental health survey in the county, she gathered certain of the gross facts about mental health from the various resources.

Admittedly, this is a fairly sophisticated use of the volunteer, and it opens up several avenues of discussion.

For one thing, our volunteer was considered to be of professional stature and was carefully briefed on all policies and procedures of the agency. She was briefed as well on the principles of confidentiality of case material.

A large allotment of time was given to the agency by the volunteer—from four to eight hours a week, or more.

The return to the volunteer for this devoted time was the professional experience and the opportunity to determine what direction to take in future educational endeavors.

No rules seem appropriate to apply to volunteers for agencies of this sort, but a few suggestions may be hazarded:

Not everyone who applies to an agency could do volunteer work on the level mentioned. Some volunteers might do work such as statistical analysis, or clerical work, but most will probably want to see patients in some capacity. Whether or not the volunteer is able to do this sort of work will depend on a careful personal appraisal.

Finally, a volunteer (or volunteers) will require supervision, and probably rather more of this than is true of an experienced employee. Whether or not a volunteer will more than "pull his own weight" will depend on the amount of supervision he requires, as balanced against the amount of work done. Of course, there are other considerations involved—some of which require careful analysis and will either indicate or rule out the feasibility of the use of the volunteer. Among these considerations are the following: (1) How the patient is introduced to the volunteer, and how he feels about receiving this help. (2) The degree of comfort or discomfort staff members experience in having a volunteer in the agency. (3) Time consideration—can the volunteer spend enough time to make the procedure worthwhile?

In the case of our own volunteer, it was felt that all of these considerations led to a positive experience for the agency and client alike. Admittedly, our situation was somewhat unique, and whether or not it is feasible to recruit and train volunteer help of this sort, remains an interesting, if unanswered question.

FEES ARE INSTITUTED IN AGENCY

For several years, the board of directors and staff had considered the possibility of instituting a fee system in the Youth Counseling Service, in order to help pay for the cost of the service. The proposal had always been defeated, primarily because one of the principal funding agencies of the Y.C.S., the City Commission of Bryan, had warned the board that the very idea of a fee for the services might discourage the most disadvantaged persons and families from seeking help, and service to the disadvantaged had been a selling point to the Commission in the beginning.

The board studied the experience of other agencies and concluded that the fee probably would not raise a significant amount of funds, and might create the wrong impression that the agency could be "self-sustaining," to too great an extent. (Agencies of this sort have raised an amount of funds, through charging fees, of something like three to ten per cent of the total annual budget.)

Finally, with the advent of the new psychiatric program, it was

decided to set up an experimental fee system, primarily in order to provide more incentive for those clients who could pay, to work more diligently on their problems. Also, fee charging has come to be an almost universal practice in such an agency.

The fee plan was presented in turn to each of the financing agencies, and was approved. However, it was necessary to underline the principle that the service would be provided, regardless of whether a fee was paid, so that those unable to pay a fee would receive the same service they had always received. This was accomplished by a fee schedule which graduated the fee according to the ability of the family to pay, as follows:

Family income $5,000 or less per year / No fee
Family income $5,000 to $10,000 / $5.00 per visit
Family income $10,000 or more per year / $10.00 per visit

Latitude was to be had in accounting for unusual circumstances which might affect the ability of a family to pay. Also, it was made clear the fee was a voluntary affair, and no attempt would be made to compel anyone to pay a fee.

So far as the staff was able to tell, there was no noticeable change in the clientele because of the fee. After the first year, during which approximately $1,500 was raised by the fee (about $500 more than had been estimated), it was discovered that this fee amount had been paid by 14 percent of the clientele, whereas 86 percent had paid no fee at all. This seemed a good indication that the service was reaching a fairly high proportion of economically disadvantaged families, or else that a high proportion of those served refused to pay. (It is our impression that the former conclusion was the most nearly true.)

There is no indication that the fee system to date has caused any significant "shift" in the type of clientele served. The service has been rendered to a highly diversified group from all economic and social levels.

BRYAN TAKES OVER THE FINANCIAL RESPONSIBILITY FOR THE NEW PSYCHIATRIC CONSULTATION PROGRAM

As the first year of the psychiatric services drew to its end, the question loomed of financing the program for a second year. The board of directors considered the problem carefully, and it was decided that the City of Bryan would be asked for an additional amount of $3,000.[16]

Accordingly, in the spring of 1964, this budget request was submitted to the City Commission.[17]

To the disappointment of the board, the budgetary increase was refused, although the former budget of $12,000 was approved. The board of directors felt that the story of the service had not been told adequately to the commission. Therefore, a special hearing before the commission was requested and granted. At this hearing, there appeared nearly the entire board of directors, as well as Dr. Moore and the staff. One citizen, not a member of the board, came forward and voluntarily attested to the service the agency had rendered to a family of modest means. This family, in gratitude, had praised the service, to this citizen, a businessman, when he approached a certain business in behalf of the Bryan United Fund drive, in the previous year's campaign. The helped family had made an unusually large donation to the United Fund in behalf of the Youth Counseling Service. The commission was obviously impressed by this testimony. They were also impressed by the direct description, by Dr. Moore, of his work during the past year, in the agency. Dr. Moore spoke also of the need for a psychiatrist in the community and the commission (1) encouraged him to come to the community to practice full time, or (2) to help locate some other competent psychiatrist to settle in Bryan.

The result of the hearing was very heartening; the commissioners granted the request for the increased budget in order to keep the psychiatric consultation program going with local funds. There was also a recommendation from the commission for a study of the agency, so that the commission could be better informed about the service, its needs, and the future course the agency should take. Two commission members were appointed to obtain the study.

[16] This raised the City allotment for the service from $12,000 to $15,000 per year.

[17] The City of Bryan has a City Managerial form of government, directed by a five-member elected Commission.

Subsequently, the commission committee submitted a questionnaire to the Youth Counseling Service, asking specific information about the number of people seen and the character of service rendered. (Previous annual reports to the commission had included answers to essentially the same questions.)

In conferring with the commission, the board learned that they felt the Youth Counseling Service was becoming an increasingly important receiver of city tax fund support. For that reason, the commissioners felt the need to have some participation in the "management" as it were, of the agency, and the formation of its policy.

Furthermore, there was a feeling on the part of the commissioners that the cost of operation was high, in terms of the relatively small number of cases seen and the size of the annual budget.

The first problem, that of more participation in the affairs of the agency, was approached in this way: The board suggested that (a) A member of the commission serve, ex-officio, on the board of directors of the Youth Counseling Service. (b) More frequent reports would be made to the commission, at least in terms of making available to them, minutes of each meeting. (c) The names of prospective board members would be submitted to the commission for their approval, in the future.

Subsequent contacts with the commission by board members showed that they seemed impressed favorably by the willingness of the board to include them in the planning phases of the agency operation, but they revealed that they were too busy to come to board meetings.

From the foregoing, it can be concluded: (a) Insufficient attention had been given to the important matter of keeping the commissioners informed of all the activities and services of the agency, which was, in their eyes, a relatively "new" and expensive undertaking for the city; and (b) it is perhaps difficult for a governing body such as this to define its own role in "directing" an agency which it helps to finance to such an important degree and (c) special efforts must be made to inform the members of such a body—politically appointed or elected and sensitive to *numbers* served.

Several approaches were taken to the question of why an agency of this sort must spend so much professional counseling time with a relatively few cases. For example, the director examined the caseload report from as many other agencies of this sort as he could learn about, and discovered that, in comparison, the caseworkers of Brazos Youth Counseling Service carried as many as, and usually relatively

more cases than other agencies of a similar nature. Case analysis also revealed a "cost per hour of direct counseling service at B.C.Y.C.S. to be from $7.38 per hour in 1959 to $8.92 per hour in 1964. This compares favorably with national figures which vary from $15 to $30 per hour, and one agency which, after a careful cost-accounting study, found the cost of each hour of counseling was $22.[18]

Another approach that seemed quite effective to this group was this: The costs of keeping a boy or girl in one of the training institutions is so high, that, if only one in 20 of the children seen at an agency such as the Youth Counseling Service are saved from such a fate, then the cost to the taxpayer is more than saved—and this does not even weigh all the other benefits which may accrue from such a program.[19]

It should be pointed out that all the other funding bodies of the agency have given excellent support to the Youth Counseling Service; only in the above-mentioned instance was there a difficulty in interpreting the work of the agency, and the need in the community for such a service.

In our experience, board members were most effective in interpreting these factors to funding bodies. A good deal of staff-board member contact, even a determined and persistent effort on the part of the staff (especially the director) was used to educate the board as to the work of the agency, its effectiveness, and the mental health needs of a growing community.

[18] (Social Casework, July, 1964, p. 393 ff.) For an excellent comparison of caseloads of different mental health agencies, see: *The Community Mental Health Center—An Analysis of Existing Models,* Raymond Glasscote, et al; American Psychiatric Association, Washington, D.C., 1964.

[19] In a speech made by Governor Connally about a year ago, he said the average cost of providing one year's care at one of the training schools was nearly $2,000.00 Other estimates for this sort of care range up to approximately $5,000.00 per year per child.

FUTURE PLANS OF BRAZOS COUNTY YOUTH COUNSELING SERVICE

At this writing, the psychiatric social worker who served as director of the agency during the foregoing project, has left the agency to take a position in a similar, but larger agency in a larger city. The Youth Counseling Service is operating under the direction of the remaining psychiatric social worker; and the board of directors, through its personnel committee, is arduously seeking for a psychiatric social worker experienced in clinical practice, community organization, and administration.

Future plans include the possible hiring of a half-time clinical psychologist, to do the necessary testing for the agency, and in order to expand the treatment program.

The board of directors is studying plans to change the name of the agency to "The Brazos County Counseling Service," or some similar title. For some time the board had recognized that the name of the agency was somewhat misleading, since considerable family and particularly marriage counseling was being carried on in the agency. Yet the board was slow to move, because of the excellent image of the agency, which already existed in the community, and because there was a fear the agency would be swamped with demands for marriage counseling, if it became known this service was to be offered.

For the latter reason, there is also a plan to hire an additional social worker, (in addition to the new director) at the time the name change is made effective. This expansion will allow more counseling to be done, of a broad family and marriage counseling nature.

The B.C.Y.C.S., through its staff and board, has also given considerable support for a proposed new development in social services for the community as well as the surrounding counties. This service, a child welfare regional unit, has been interpreted as a logical and effective help to the B.C.Y.C.S. and Probation Office. (The probation office is presently designated as the official agency to serve dependency and neglect cases.)

Also, the B.C.Y.C.S. has participated, through considerable board and staff (as well as community work, particularly through practicing physicians) in obtaining one or more psychiatrists to practice locally, and, incidentally, to act as consultant(s) to the B.C.Y.C.S.

Presently, the arrangement with the Houston State Psychiatric Institute continues effective, and a psychiatric consultant is still going to Bryan on a weekly basis.

Finally, the board, primarily at the suggestion of and with the consultative help of The Division of Mental Health, State Department of Public Health, has promoted the organization of a mental health survey for Brazos County. At this point, a broadly representative community steering committee has been appointed and it, in turn, has appointed a chairman to direct the final phases of the survey. Materials which were obtained from the Division of Mental Health include a "Guide to Action"[20] which outlines the objectives and usual procedures in making such a survey, as well as suggested survey guides and questionnaire forms.

This sort of undertaking might well be the beginning point of any effort, on the part of a community, to set up a mental health service. Through such a survey, several aims might be accomplished. (a) The coordination and "education" of community leadership, to the end that effective planning be made for community action. (b) Agreement that a particular project (or projects) should be attempted before something else—or in other words, the establishment of priorities. It might well be that a community, armed with a mental health survey, would decide to establish some other service such as a child welfare unit or a visiting teacher service before initiating a drive for a specific agency such as that described in these pages.

IN CONCLUSION

"Daniel," at this writing, has finished the second grade, as part of a regular school class, albeit a "handpicked" and devoted teacher was chosen who consulted several times with the B.C.Y.C.S. psychiatric social worker. Probably this service enabled Daniel to obtain this school experience, when otherwise the school would have been unable to maintain him in the class.

Daniel now plays at aggressive contact sports, not with phantoms but with real people, something hardly possible at the outset of his diagnostic and treatment period. He still needs treatment and help, and his parents need counseling, if he is to continue to grow and develop emotionally. Many of the scary phantoms appear to have vanished from Daniel's phantasy, and his door-slamming symptom has disappeared completely. We are grateful to him for having opened the door to the present fine psychiatric consultation program —a door that is still open, and hasn't been banged shut yet!

[20] "*Guide to Action* for Development of Community Mental Health Services." Prepared by Division of Mental Health, Texas State Dept. of Health, 1963.

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